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# The Medicare+Choice Program: Taking Stock After One Year

presented to

Subcommittee on Health and Environment
Committee on Commerce
United States House of Representatives

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Chair

October 2,1998

Good morning, Mr. Chairman. I am Gail Wilensky, Chair of the Medicare Payment Advisory Commission. With me today is Murray Ross, MedPAC's Executive Director.

In August one year ago, the Balanced Budget Act (BBA) of 1997 created Medicare+Choice, a new program intended to give Medicare beneficiaries new choices of private health plans, slow the growth in Medicare spending, and better target the program's resources. The new program takes effect January 1, 1999, although many provisions will not kick in until January 1, 2000.

Two reasons make this an opportune time to take stock of the new program. First, we now have information about how the Health Care Financing Administration (HCFA) proposes to implement Medicare+Choice. The agency issued an interim final rule on June 26th that laid out the ground rules for plans seeking to participate in the new program and published a notice on September 8th describing its proposed method of risk adjustment.[1]

The second reason concerns widely-publicized withdrawals of health plans from the Medicare market and the limited number of new types of plans that have indicated their

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[1] See *Medicare Program: Establishment of the Medicare+Choice Program* (63 Fed. Reg. 34968) and *Medicare Program: Request for Public Comments on Implementation of Risk Adjustment for the Medicare+Choice Program and Announcement of Public Meeting* (63 Fed. Reg. 47506).

intent to participate in the Medicare+Choice program. Policymakers are concerned that these events suggest the new program may not achieve its goal of expanding choices.

My testimony today describes the Medicare+Choice program, discusses the steps HCFA has taken in implementing it, and reports MedPAC's advice to the HCFA Administrator regarding the steps taken to date. I will also discuss the Commission's reaction to developments in the Medicare managed care market. Two main points flow from this discussion:

- MedPAC supports the agency's effort to harness Medicare's purchasing power to improve the quality of care for beneficiaries. We urge HCFA to apply standards to plans in a way that encourages innovation and variety in the delivery of health care. MedPAC supports the introduction of new risk adjustment methods to make payments to health plans correspond more closely to the expected cost of serving their enrollees. In view of the limitations in the interim method that has been proposed, however, MedPAC recommends that this method of risk adjustment be phased in, and urges HCFA to move to a method based on more comprehensive data as quickly as feasible.

- Recent plan withdrawals from the Medicare managed care program are clearly not

what the Congress expected. The Commission cautions against reopening the BBA to make significant changes to the new program until the causes of these developments are better understood. At the same time, we recognize that plan withdrawals may have financial consequences for enrolled beneficiaries in some areas who may be pushed back into the Medigap market. Given the special circumstances during this transition year, HCFA should work with plans to find steps that could ameliorate the difficulties many plans face without raising program costs.

## The Medicare+Choice Program

The Medicare+Choice program replaces the existing section 1876 risk contracting program and permits participation by a wide variety of private health plans. Under the new program, beneficiaries will be able to choose—in areas where they are offered—among a variety of coordinated care plans, including health maintenance organizations (HMOs) with or without a point-of-service option, preferred provider organizations (PPOs), and provider-sponsored organizations (PSOs). In addition, beneficiaries may enroll in private fee-for-service plans, and high-deductible plans offered in conjunction with a medical savings account (MSA).

The BBA modified the framework in which private health plans participate in Medicare, changing the responsibilities of both HCFA and participating plans. Notable among these changes is HCFA's new obligation to help beneficiaries make informed choices by routinely providing them comparative information about quality, access, financial liability, satisfaction, and financial stability for all plans serving their area. Participating plans are required to report detailed information to enable HCFA to undertake this responsibility and to facilitate program quality assurance. The BBA also established the framework for the Medicare+Choice quality assurance program, which features requirements for quality improvement activities and external quality review that differ by plan type.

The BBA also made significant changes in the way health plans are paid, by severing the link between county-level trends in fee-for-service spending and payment updates to plans, instituting a floor under county payment rates, blending local and national payments rates, and removing the component of base rates attributable to spending for graduate medical education. Further, it directed the Secretary of Health and Human Services to implement risk adjustment by January 1, 2000.

Until 1998, Medicare's payments to private health plans in a county were based on the average payments made on behalf of beneficiaries in its traditional fee-for-service

program in that county. Under the Medicare+Choice program, payment rates are no longer based solely on local fee-for-service spending. Instead, base payment rates for each county are calculated as the higher of:

- a blend of an area-specific (county) rate and a national rate;
- a minimum or floor rate; or
- a rate reflecting a minimum update of the county's rate from the previous year.

The blended rate is designed to shift payment gradually away from local county rates, which reflect wide variation in fee-for-service costs and use of services, toward a national average rate. Blending will generally reduce payment rates in counties where payment rates have historically been higher than the national average rate, and will increase rates in counties where payments have been lower. Other things being equal, this should stimulate plan participation and beneficiary enrollment in areas where payments rise and dampen enrollment growth—and perhaps plan participation as well—in areas where payments fall.

**MedPAC's Comments on HCFA's Proposals for the Medicare+Choice Program**

HCFA's interim final rule (the rule) establishing the Medicare+Choice program

addresses a number of issues, including information for beneficiaries, quality assurance, and payments to participating plans. This section summarizes MedPAC's comments on these provisions where HCFA had discretion in implementing the BBA.[2]

**Information for Beneficiaries.** Medicare+Choice organizations will be required to provide certain information to their enrollees upon enrollment and annually thereafter. Routinely disclosed information must be provided in a clear, accurate, and standardized format and describe the plan's service area, benefits, number and mix of providers, coverage arrangements for out-of-area and emergency care, supplemental benefits and related premiums, prior authorization rules, procedures for filing grievances and appeals, disenrollment rights and procedures, and quality assurance program.

Recognizing that comparative information is critical both to empower beneficiaries and to support program oversight, MedPAC supports the information disclosure requirements established in the BBA and reiterated in the rule. However, as HCFA begins to develop specific reporting requirements, it should take care to weigh the informational value of each item against the costs borne by plans and providers in reporting it. Further, HCFA should carefully coordinate the information requirements it imposes on its plans with the encounter data standards it establishes to support risk adjustment of payments. To the

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[2] The complete text of MedPAC's official comments are contained in a September 10th letter to the Administrator of HCFA. Copies of this letter, as well as a MedPAC staff summary of the rule, are available from the Commission.

extent possible, both disclosure requirements and encounter data needs should be met using common data elements with consistent definitions and measures.

**Quality Assurance.** As directed by the BBA, the rule requires participating plans to have an ongoing quality assessment and performance improvement program. All plans will be required to maintain information systems to collect, integrate, and analyze the data needed to assess and improve quality. They will also have to ensure the reliability and completeness of data collected from providers. Coordinated care plans—but not MSA plans or private fee-for-service plans—will be obliged to achieve minimum performance standards established by HCFA. Coordinated care plans and network MSA plans must also conduct projects to demonstrate sustained improvement in significant clinical and nonclinical aspects of care.

Implementation of these quality standards will pose formidable challenges. Yet to be addressed are issues such as:

- how to set standards without unduly restricting innovation and competition;
- whether quality measures can be identified that would permit meaningful comparisons across different types of plans and between those plans and traditional Medicare;

- how to adjust for important differences in enrolled populations when reporting performance measures; and
- how to reduce opportunities for manipulating the system at junctures such as choice of quality improvement project.

MedPAC is also concerned that the quality assurance system set forth in the rule will pose significant barriers to participation for all but the most tightly managed coordinated care plans. For example, plans with large, loosely organized networks may face challenges reporting certain types of quality measures or influencing practice behavior. MedPAC recognizes the value of establishing common standards where possible, but believes that different standards will be necessary in some instances to reflect differences in plans' organizational structures and roles in care management. The Commission suggests HCFA consider additional ways to create equivalent standards where uniform standards are not feasible.

**Payments to Medicare+Choice Organizations.** As with other topics addressed by the rule, the regulations concerning payment closely follow the BBA. In several areas, though, HCFA has used general program administration authority to define payment policies that are more prescriptive than was the case in the section 1876 risk contracting program.

*Uniform Benefits and Plan Service Area Policy.* Medicare's payment rates can vary considerably, even among counties within a single metropolitan area. Under the old risk program, plans could offer different benefit and premium combinations in different counties within their service areas to reflect differences in Medicare's payment rates. Current risk contractors will continue to be allowed to offer flexible benefits in 1999, as a transition to Medicare+Choice status. After that, however, plans must provide uniform benefits at a uniform price to all enrollees across their entire service areas.

One way plans could continue to offer coverage across areas with diverse payment levels would be to divide their service areas into smaller units and match their benefit packages to the payment rates. But the preamble to the rule suggests that after 1999, plans will meet resistance in the plan approval process if they do this. Further, the rule requires service areas to stand alone in terms of meeting network access requirements. If plans could not meet these requirements, Medicare+Choice organizations might decide not to serve these counties at all. The Commission is concerned that beneficiaries in low-payment counties may have decreased access to Medicare+Choice plans as a result.

The Commission thus recommends that the agency maintain flexibility in this process and seek a legislative change that will allow flexible benefit offerings across counties. In the absence of such a change, plans may have difficulty providing uniform benefits

across multi-county service areas because of differences in payment rates, and might abandon lower paying counties in metropolitan areas. This would be to their advantage because they could offer richer benefit packages than could plans with wider service areas that continued to average in the lower payments from the other counties.

*Adjusted Community Rate Proposal Calculation.* The rule revises the adjusted community rate (ACR) proposal, essentially changing it from an actuarial estimate of costs to a report of actual costs incurred, with allowable adjustments. Administrative costs will be separated from additional revenues, which include profits, contribution to surplus, risk margins, and contributions to risk reserves.

MedPAC supports efforts to improve the ACR by making it better reflect actual costs. However, an ACR based on reported costs will probably require plans to provide more benefits and give them less financial slack to make up for unanticipated fluctuations in costs or payments, or errors and biases in accounting systems. HCFA should therefore monitor the impact of changes to the ACR and revisit policies regarding the benefit stabilization fund (a fund into which plans may contribute surplus payments to allow the provision of stable benefit packages over time).

In addition, the Commission advises examination of alternatives to the ACR for ensuring

good value from private fee-for-service and MSA plans. Various aspects of the standard ACR approach do not work well for these plans, but it may be reasonable and desirable to have plans report the relevant ACR information, or to develop reporting standards that would ensure good value for beneficiaries. At a minimum, all plans should be able to report their Medicare costs.

*Adjusted Community Rate Proposal Review and Audit.* The BBA and the rule provide for increased federal government scrutiny of ACR proposals, with the former requiring that data be audited, and the latter requiring that organizations certify data accuracy.

MedPAC urges the allocation of adequate funds and personnel for these functions. The Commission believes that beneficiaries should share in the efficiencies of managed care plans and is concerned that the ACR is the only way to enforce this requirement in areas with minimal competition. HCFA should develop reports on the value delivered by plans, and should focus audits and review of data and assumptions on areas where payments exceed costs in traditional Medicare and on plans—particularly those offered by provider-sponsored organizations—in markets with little competition. At the same time, MedPAC recognizes that Medicare+Choice organizations need time to adapt accounting systems to produce ACR proposals using the new methods. The Commission recommends HCFA take this into account in its review of ACR calculations and data.

**Risk Adjustment.** Risk adjustment is the process of setting capitation rates that reflect health status, paying plans more to care for ill beneficiaries than for healthy ones. Through 1999, monthly payments to private health plans under Medicare will continue to be based on the current risk adjustment method, under which payment to a plan for a particular enrollee is the product of the base payment amount for the county and the enrollee's risk score. Until this year, the base payment reflected 95 percent of the amount Medicare would expect to spend on behalf of an average beneficiary in the traditional fee-for-service program in that county. (For 1998, the base payment rate was set using the rules laid out in the BBA.) The risk score, which is assigned on the basis of an enrollee's age, sex, eligibility for Medicaid, and whether or not the enrollee is institutionalized, reflects expected spending for that enrollee compared with spending for the average Medicare beneficiary in the traditional fee-for-service program.

Medicare's existing method of risk adjustment is widely acknowledged to be inadequate because its components account for very little of the variation in beneficiaries' health and use of health care services. As a result, program spending has been higher than it would have been had payments more closely matched the cost of caring for the relatively healthier people who enrolled in managed care. Inadequate risk adjustment leads to health plans having gains and losses unrelated to their efficiency in delivering care, and may also affect access to care for beneficiaries with high-cost health conditions. In 1997,

both the Physician Payment Review Commission and the Prospective Payment Assessment Commission recommended that Medicare adopt risk-adjusted capitation rates based on health status to mitigate these problems.

The BBA provided a specific mandate and timetable for improving risk adjustment in the Medicare program, directing the Secretary to develop and implement a new risk adjustment methodology by January 1, 2000. This deadline in turn requires the Secretary to announce the risk and other factors that will be used to adjust county-level payment rates by March 15, 1999. However, as a practical matter, HCFA will have to establish its methodology much sooner.

In its September notice, HCFA proposed to implement a risk adjustment system based on enrollees' demographic characteristics and expected relative health status. Initially, health status would be measured using principal inpatient diagnostic cost groups (PIP-DCGs), and principal diagnoses associated with any hospital stays that occurred during the preceding year. That is, the risk score for an enrollee is intended to reflect the enrollee's higher expected costs in the year following a hospitalization. Information about prior hospital stays would be obtained from encounter data submitted by plans for current enrollees and from fee-for-service claims for new enrollees. Some time after 2002, the agency would incorporate information from encounter data from additional

sites of care for the purposes of risk adjustment.

*Effect of Risk Adjustment on Payments.* The new risk adjustment method will change payments to health plans both individually and in the aggregate. Payments to individual plans are likely to change because the new system will be much more sensitive to differences in health status among beneficiaries, so that the average risk score for plans' enrollees may vary substantially. In addition, aggregate payments to plans are likely to decline because the relative healthiness of enrollees—which has not been captured by the current risk adjustment system—will be captured, to some extent, under the new system.

*Issues.* HCFA's proposed risk adjustment system raises both near- and longer-term issues. In the near term, key questions include:

- What should be done if the encounter data now being collected are inadequate?
- How should payments for new Medicare beneficiaries—for whom no encounter data or fee-for-service claims will be available—be set?
- Should the new method be phased in to avoid wide swings in payments?
- Should an outlier policy be adopted to protect plans that enroll a large percentage of beneficiaries with unexpectedly high costs?

Over the longer term, key questions include:

- How can the model be expanded to account for predictable costs other than those attributable to an inpatient hospital stay?
- Should a multi-year risk adjustment model be adopted to account for predictably higher spending beyond the first year following a hospital stay?

*MedPAC's Comments.* In our March 1998 *Report to the Congress: Medicare Payment Policy*, MedPAC made a number of recommendations with regard to risk adjustment. One key recommendation was that Medicare should move as quickly as feasible to develop the capability to use diagnosis data from all sites of care for risk adjustment. We continue to be concerned with the incentives inherent in a risk adjustment system in which health status is measured solely by hospital inpatient diagnoses. Inpatient data are easier to collect, but relying solely on them distorts incentives regarding hospitalization. It encourages plans to favor inpatient over outpatient modes of treatment, and it penalizes plans that are good at substituting ambulatory care for hospital stays.

In the interim final rule issued in June, HCFA noted that it will provide advance notice to Medicare+Choice organizations to collect and submit data on the use of physician, hospital outpatient, skilled nursing facility, and home health agency services, and that the

submission of such data will be required no earlier than October 1, 1999. This timetable will permit implementation of a risk-adjustment system that uses this non-hospital data no earlier than 2003.

MedPAC is concerned about leaving an interim system in place for three or more years and believes there should be a substantial effort to move Medicare+Choice payments quickly beyond such a system.

A second recommendation in our March report was that, as soon as feasible, HCFA should refine its risk adjustment methodologies to allow for the persistence of higher expected costs beyond the first year following diagnosis of a serious condition. Under the single-year method, the rate paid for an enrollee will fluctuate inappropriately over time for many enrollees. We recognize, however, that developing and testing such a refinement is a complicated task that might not be completed for four or five years.

Finally, MedPAC recommended that Medicare undertake a large-scale demonstration of partial capitation or other methods that would pay plans partly on the basis of a capitated rate and partly on the basis of payment for services used. By itself, risk adjustment may reduce incentives for risk selection, but it will not create neutral financial incentives for plans to provide specific services. Risk sharing in the form of partial capitation may be

more economically neutral than either fee-for-service payment or capitation alone.

In addition to these recommendations, MedPAC is currently reviewing HCFA's September notice and will make comments available early next week. Those comments will expand our advice to HCFA regarding phase-in methods that could be adopted to temper the effect of risk adjustment on payment rates. One approach might be to establish corridors around the annual change in each plan's payments per enrollee. Alternatively, a phase-in might be accomplished by blending the payment amounts that would apply under the current system with those that would apply under the interim system. However, both of these phase-in methods would permit plans to continue receiving higher payments than the best available risk measure suggests they should receive.

**Next Moves**

While the Medicare+Choice provisions of the BBA greatly expanded the array of plans eligible to participate in Medicare, only three non-HMO plans had sought to do so as of late August. And over the past few months, a number of plans have announced their intention to withdraw from or scale back their operations in particular Medicare markets. While some of these withdrawals are related to developments in the broader health

insurance market, many plans have cited low Medicare payment rates and concerns about the costs of meeting the standards of the Medicare+Choice program as the reason for their actions.

These developments have raised questions in the minds of policymakers about whether the promise of the Medicare+Choice program will be realized and whether action is needed to boost payment rates to avoid future withdrawals, to modify certain regulatory requirements, or to mitigate the effects of risk adjustment. While these are clearly important questions, we are not yet in a position to give definitive answers to them. Two general considerations are relevant, however.

First, we note that in passing the BBA, Congress intended to slow the growth in payments to private plans and to make payments more equitable across counties—through blending—and across plans—through risk adjustment. By their very nature, these policies will change payment rates in ways that lead plans to retrench in some areas and to take advantage of opportunities newly available to them in other areas. The passage of time will help us determine whether this is taking place. Sudden changes in local markets are clearly a concern, however, and enrollment and plan participation should be closely monitored to guard against disruptions in beneficiaries' health care.

Second, circumstances during this transition year are unique. When the implementing regulation came out in June, existing plans had already filed their ACR proposals and could not account for any new costs imposed by the rule. New plans had little time to make decisions about whether to participate in 1999. Combined with continuing uncertainty about the impact of risk adjustment, it is likely that many plans adopted a wait and see attitude. Next year should provide better evidence of whether plans will participate in the program and how beneficiaries will react to their new choices.

While the lack of good information makes it premature to reopen the BBA, these considerations suggest recognizing this year's special circumstances. HCFA should work with plans to see if changes in regulation—such as postponing implementation dates, reviewing aspects of the quality assurance program to find better or less costly ways to collect data, or allowing plans to revise their ACRs—could ease the difficulties faced by plans and preserve beneficiaries' access while not raising program costs.

This concludes my prepared statement. I am happy to answer your questions.